



JON S. CORZINE
Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs

Drug Control Unit

124 Halsey Street, 3rd Floor, Newark, NJ 07102



STUART RABNER
Attorney General

STEPHEN B. NOLAN
Acting Director

Mailing Address:

P.O. Box 45045
Newark, NJ 07101
(973) 504-6351

Controlled Dangerous Substance Registration Instruction sheet

Enclosed is a Controlled Dangerous Substance (C.D.S.) application, which you are required to submit pursuant to N.J.S.A. 24:21-1 et seq. Registration is required for every person who, or firm that, manufactures, prescribes, distributes, dispenses or conducts research or analysis utilizing controlled dangerous substances.

A New Jersey C.D.S. registration is issued only for a New Jersey location. Be sure to include a \$20.00 check or money order, payable to "Treasurer-State of New Jersey." It will take 4-6 weeks to process this application. Your C.D.S. registration will be mailed to the mailing address on file with your professional licensing board.

Please note:

1. If you have a current D.E.A. number in another state and plan to discontinue practice in that state, you may transfer that D.E.A. number to New Jersey by providing the following to the Drug Enforcement Administration, 80 Mulberry Street, Newark, New Jersey 07102, (888-356-1071) www.deadiversion.usdoj.gov:
 - a. a copy of your New Jersey professional license or a verification letter from the licensing board;
 - b. a copy of your New Jersey C.D.S. registration or a verification letter;
 - c. a copy of your out-of-state D.E.A. registration; and
 - d. a letter requesting an address change to the same address that is on your New Jersey C.D.S. registration.

A D.E.A. number is only valid in the state listed on the certificate.
2. If you plan to practice in both New Jersey and the state(s) where you currently hold a D.E.A. registration(s), you must also obtain a D.E.A. registration for New Jersey. Please contact the D.E.A. at the address indicated above and complete the New Jersey application.
3. In order to complete the attached application, please note:
 - a. A dispenser or prescriber includes medical doctors, doctors of osteopathy, dentists, veterinarians, podiatrists, advanced practice nurses, pharmacies and certified nurse midwives.
 - b. Every person or firm handling controlled dangerous substances in New Jersey is required to have both a state and federal registration for that purpose. Federal facilities **do not** require registration.
 - c. The address supplied must be current and an actual location where controlled dangerous substances will be stored, prescribed, dispensed, etc. **The address cannot be solely a post office box.**
 - d. Dentists may only register at the address for which they hold a current registration issued by their board and at which the C.D.S. registration is required pursuant to 3(c) above.
 - e. Individual practitioner applicants (medical doctors, dentists, veterinarians, etc.) must use their own name, not professional association/corporation or partnership information.
 - f. Pharmacies are required to use their common trading name (e.g. David Pharmacy), not a business or corporate name.
 - g. Dispensers/Prescribers must have an active and current New Jersey professional license number. **Please write in your New Jersey professional license number in "Section B" of the application.**
 - **Advanced Practice Nurses may prescribe controlled dangerous substances. Advanced Practice Nurses may not purchase or maintain any stock supplies of any C.D.S. medication.**
4. If more space is required for your response to any question on the application, please submit a separate sheet of paper identifying the section(s) to which you are responding.

If we can be of further assistance, please call 973-504-6351.

New Jersey Office of the Attorney General
Drug Control Unit
P.O. Box 45045
Newark, NJ 07101



**Initial Application for Registration
for Dispenser/Prescriber Practitioner**

New Jersey Controlled Dangerous Substances Act
N.J.S.A. 24:21-1 et seq.

Please type or print firmly with a ballpoint pen.

Section A: All of the items in this section must be completed.

1. Provide the applicant's name and the place of business (or, if unavailable, the New Jersey residence) to be registered (do not use solely a P.O. box). Registration is provided for New Jersey locations only. If the registration is for a University of Medicine and Dentistry of New Jersey facility, include the department, room number, designation, e.g. M.E.B., M.S.B., etc. The address of record must be your practice location.

Last name First name MI
C.D.S. - Responsible Individual

Department Room number

Street address

City State ZIP code

Home telephone number (include area code) Business telephone number (include area code)

Note: Please note that the above-registered address is subject to inspection pursuant to N.J.S.A. 24:21-31 & 32.

2. Registration requested as: Dispenser/Prescriber (\$20)
Make the check or money order payable to: Treasurer - State of New Jersey.

3. Registration requested for: ☐ Schedules II through V
If registration is being requested for only certain Schedules, please indicate which Schedules: ☐ II ☐ III ☐ IV ☐ V

4. (a) Has any restriction been imposed which would affect your privilege to hold a controlled dangerous substances (C.D.S.) registration for Schedule II, III, IV or V substances in New Jersey, any other state, the District of Columbia or in any other jurisdiction?*
- ☐ Yes ☐ No
- (b) Have you been arrested, indicted or convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?*
- ☐ Yes ☐ No
- (c) Have you ever surrendered a controlled drug registration or had a controlled drug registration revoked, suspended or denied in New Jersey, any other state, the District of Columbia or in any other jurisdiction?*
- ☐ Yes ☐ No
- (d) If the applicant is a corporation, association, or partnership: has any officer, partner, stockholder holding 10% or more of the outstanding shares or employee who has access to controlled dangerous substances been convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?*
- ☐ Yes ☐ No
- (e) If the applicant is a corporation, association, or partnership: has any officer, partner, stockholder holding 10% or more of the outstanding shares or employee who has access to controlled dangerous substances surrendered a controlled drug registration, had a controlled drug registration suspended, revoked, or denied, or owned or worked for an entity which has surrendered or had revoked, suspended, or denied a controlled drug registration under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?*
- ☐ Yes ☐ No

*** If "Yes," attach a letter setting forth the circumstances of such action.**

Section B: Dispenser/Prescriber (check category)

1. ☐ M.D. 4. ☐ Veterinarian
2. ☐ D.O. 5. ☐ Podiatrist
3. ☐ Dentist License number _____

Note

1. You must also obtain a D.E.A. registration for the same New Jersey address of record.
2. Dentists may only register at a New Jersey address for which they hold a current registration issued by their board.

Section C: Dispenser/Prescriber Identifying Data

3. *Social Security Number: _____ - _____ - _____

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

*Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128 E(b)(2)A of the Social Security Act, the Unit or licensing agency to which this form is submitted is required to obtain your Social Security number. If you do not have a Social Security number, the Unit must ascertain the reason that you do not have one. The Unit is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b))), the Unit or licensing agency to which this form is submitted is requesting the voluntary disclosure of your Social Security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Unit or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure or certification and disciplinary proceedings.

I, _____, ☐ Consent ☐ Do Not Consent
Applicant's signature

to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

Section D: Certification

I, _____ being duly sworn, depose and say under penalty of false statement, that I am the person described and identified in this application; that the information given in this application and all submitted materials contain no willful misrepresentations and that the information is true and complete. I understand that should an investigation at any time disclose otherwise, my application may be rejected, and I may face legal sanctions if I am already registered. I understand that in signing this application for registration, I am consenting to any reasonable inquiry that may be necessary to verify the information that I have provided on this form or may provide in conjunction with this application.

Applicant's full signature Date

FOR STATE USE ONLY

C.D.S. number _____ Effective date _____ Expiration date _____

Retain the last copy for your records. Mail the remaining copies with your fee to the above address.